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ORIGINAL ARTICLE

The Quality and Utility of Referral Letters for Gender-Affirming Surgery

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Abstract

Purpose: The World Professional Association for Transgender Health (WPATH) recommends referral by a mental health professional for gender-affirming chest and genital surgeries. However, several transgender health guidelines propose an informed consent model of care to respect patient autonomy. This research aimed to understand, characterize, and asses the quality of information gathered through referral letters for patients consulting for gender-affirming surgeries.

Methods: A retrospective review of electronic medical records (EMRs), including referral letters from behavioral health (BH) and primary care providers (PCPs), was conducted for patients seeking chest or genital surgery by a single surgeon between 2017 and 2019. Data were abstracted manually and included medical and gender history and documentation of WPATH-recommended surgical criteria.

Results: A total of 233 patient records, including 171 PCP letters and 231 BH letters, were reviewed. With respect to documentation of surgical criteria, 92% of BH letters documented a diagnosis of gender dysphoria, 63% ability to provide informed consent, and 51% management of BH comorbidities. More than half of individuals with chronic physical health conditions did not have those conditions documented in their referral letters. Similarly, BH letters often failed to document BH diagnoses endorsed by patients. For example, while 80% of patients endorsed a diagnosis of anxiety, more than half did not have it documented in their letters. Overall, greater than half of diagnoses across BH conditions were only documented as present in the EMR.

Conclusion: Referral letters only variably documented WPATH-recommended surgical criteria and did not reliably document physical and mental health comorbidities. Our research suggests that multidisciplinary presurgical assessment may be more useful than referral letters in some settings.

Keywords: gender-affirming surgery; referral letters; standards of care; World Professional Association for Transgender Health

Introduction

An estimated 0.7% of young people between the ages of 13 and 24 in the United States identify as transgender, and a growing number of transgender and gender-diverse individuals are presenting for gender-affirming surgical care.[1–4] Currently, the World Professional Association for Transgender Health's *Standards of Care* (WPATH *SOC*) recommend "documentation of persistent gender dysphoria by a qualified mental health professional" as a criterion for all gender-affirming surgeries of breast/chest and genitals.[5] The *SOC* suggest documentation of several additional criteria, including patient capacity to make an informed decision and consent for treatment, and "reasonably well-controlled" medical and mental health concerns. One referral from a mental health professional is recommended for chest

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surgery, and two for genital surgery. For genital surgery, recommended criteria also include receiving hormone therapy and living in a gender role aligned with gender identity for a duration of 12 months.

In contrast to the requirement of referral letters, several transgender health guidelines and practicing clinicians have proposed an informed consent model of care in an effort to respect patient autonomy in electing health care options without the need for mental health evaluation and approval.[6–9] Several advantages to an informed consent model of care have been suggested, although not all informed consent models are equal.[10] The requirement of a referral letter from a mental health professional before accessing medical care may be received as a form of gatekeeping, and contribute to distrust of mental health professionals among the transgender community.[11,12] Furthermore, it may pressure transgender individuals to tell a stereotypical narrative of their gender dysphoria, or letter writers to imply such a narrative, rather than facilitating an open and honest discussion of their experiences.[13] Similar pressures may also exist in the surgical setting, depending on the structure of the consult, and ideally providers working in this space should be trained to facilitate open, nonjudgmental discussion. Although ideally clinicians engage in detailed gender assessment regardless of the presence of letters, an informed consent model of care also acknowledges and supports the capability and responsibility of providing clinicians to engage in nuanced discussions regarding a patient's gender identity rather than relying primarily on external information. Understanding the role played by referral letters can help guide the development of a model of care that both respects patient autonomy and ensures nonmaleficence.

A small number of studies have described the process of composing referral letters for gender-affirming surgeries and offered guidance for doing so.[13,14] However, evidence regarding the quality and impact of referral letters remains absent from this literature. The primary objective of this research was to understand and characterize the amount and utility of information gathered through referral letters for gender-affirming surgeries in a cohort of patients undergoing consultation at a multidisciplinary specialty clinic. Specifically, this study aimed to determine how frequently referral letters documented surgical criteria recommended by WPATH *SOC*, to describe health information contained in referral letters, and to compare this information with that assessed by the multidisciplinary team and documented elsewhere in the electronic medical record (EMR).

Materials and Methods

A retrospective review of notes and referral letters contained within the EMR was conducted for patients who had sought gender-affirming surgery with a single plastic surgeon between 2017 and 2019. Patients who underwent consultation for chest reconstruction, breast augmentation, metoidioplasty, phalloplasty, and vaginoplasty were included. All visits were covered by insurance. This study was determined to be exempt from review by the Institutional Review Board of Boston Children's Hospital (IRB-P00033174).

Surgical consultation

During initial surgical consultation, patients met with a multidisciplinary team of health care providers, which typically included the team's social worker, physician assistant, nurse, and surgeon. Routine assessment included review of the patient's medical, social, and gender history, as well as evaluation of factors affecting surgical safety and readiness, such as ability to take time off from work or school and supports available to assist with post-surgical care. This information was documented in both structured and unstructured fields within the EMR.

Letters of support provided by patients were scanned into the medical record, most often after the initial consult. During the period where patients were seen, they were not required to provide referral letters before the consult. When letters arrived, whether that was before the consult or after, they were reviewed by the team physician assistant, social worker, and surgeon.

Data abstraction

Data were abstracted manually by the study's first author into a structured abstraction table using Research Electronic Data Capture (REDCap), a HIPPA-compliant, web-based application. Abstracted data included demographic information, medical, behavioral, social, and gender history, and documentation of WPATH surgical criteria.

Data analysis

Data were analyzed using statistical software STATA/SE 14 (StataCorp LLC, College Station, TX). Descriptive statistics were generated and are reported as frequencies and proportions or mean ± standard deviation, unless otherwise indicated. Multivariate linear regression was used to assess for associations between the number of WPATH surgical criteria documented and

patient age, type of surgical procedure sought, and whether the patient was receiving medical gender care elsewhere within the hospital or was an external referral.

Results

A total of 233 patient records were reviewed, of which 140 (60%) were for patients presenting for chest surgery and 93 (40%) were for patients presenting for genital surgery. Among chest surgery patients, 120 records (86%) included a referral letter from a primary care or hormone provider (PCP) and 122 (87%) at least one letter from a behavioral health (BH) provider. Among genital surgery patients, 51 records (55%) included a referral letter from a PCP and 58 (62%) at least one letter from a BH provider. Average age among chest surgery patients was 18 years (range 13–33, SD 3.4), and among genital surgery patients was 23 years (range 15–33, SD 5.4). Across all patient records reviewed, a plurality of patients were White (49%) and the majority identified as male, transgender male, or transmasculine (83%). Just over half of patients (51%) were internal referrals from the hospital's Gender Multispecialty Service (GeMS) (Table 1). GeMS referrals provided letters either from the internal providers or outside therapists, although their charts were also reviewed.

The frequency of documentation of surgical criteria recommended in WPATH's *SOC* was assessed in referral letters from PCPs and BH providers. Across all referral letters from PCPs, 151 (88%) documented a diagnosis of gender dysphoria, 97 (57%) documented ability to provide informed consent for the procedure being sought, and 75 (44%) documented that physical health comorbidities were well managed. A statement that criteria for surgery were met was documented in 41 (24%) PCP letters, and 155 (91%) authors stated their availability for coordination of care. Across all referral letters from BH providers, 213 (92%) documented a diagnosis of gender dysphoria, 145 (63%) documented ability to provide informed consent for the procedure being sought, and 118 (51%) documented that BH comorbidities were well managed. A statement that criteria for surgery were met was

Table 1. Patient Demographics, by Type of Surgical Consultation

	All patients, *N* = 233	Chest surgery patients, *N* = 140	Genital surgery patients, *N* = 93
Age mean (range, SD)	20.2 (13–33, 4.9)	18.2 (13–33, 3.4)	23.1 (15–33, 5.4)
Assigned sex at birth, *N* (%)			
Male	32 (13.7)	4 (2.9)	28 (30.1)
Female	201 (86.3)	136 (97.1)	65 (69.9)
Gender identity, *N* (%)			
Male, transgender male, or transmasculine	193 (83%)	128 (91%)	65 (70%)
Female, transgender female, or transfeminine	201 (86.3)	136 (97.1)	65 (69.9)
Nonbinary, genderqueer, or gender nonconforming	15 (6%)	13 (9%)	2 (2%)
Other	2 (<1%)	1 (<1%)	1 (1%)
Race and ethnicity, *N* (%)			
White	115 (49.4)	80 (57.1)	35 (37.6)
Black or African American	11 (4.7)	8 (5.7)	3 (3.2)
American Indian or Alaska Native	3 (1.3)	3 (2.1)	0
Asian	5 (2.2)	2 (1.4)	3 (3.2)
Native Hawaiian or Pacific Islander	0	0	0
Hispanic or Latinx	9 (3.9)	6 (4.3)	3 (3.2)
No data	98 (42.1)	48 (34.3)	50 (53.8)
Internal referral, *N* (%)	118 (50.6)	95 (67.9)	23 (24.7)
PCP letter on file, *N* (%)	171 (73.4)	120 (85.7)	51 (54.8)
BH letter on file, *N* (%)			
One letter	129 (55.4)	114 (81.4)	15 (16.1)
Two letters	51 (21.9)	8 (5.7)	43 (46.2)
Type of surgical consultation,[a] *N* (%)			
Breast augmentation	4 (1.7)		
Chest reconstruction	136 (58.4)		
Metoidioplasty	13 (5.6)		
Phalloplasty	59 (25.3)		
Vaginoplasty	31 (13.3)		

[a]Types of surgical consultation are not mutually exclusive (e.g., a patient considering metoidioplasty and phalloplasty would be counted in both categories).

BH, behavioral health; PCP, primary care providers; SD, standard deviation.

Table 2. Documentation of Surgical Criteria in Referral Letters, *N* (%)

WPATH criterion	Primary care provider letters, *N* = 171	BH letters, *N* = 231
Diagnosis of gender dysphoria	151 (88.3)	213 (92.2)
Patient adherence to treatment	78 (45.6)	104 (45.0)
Decision-making capacity	106 (62)	174 (63.6)
Ability to provide informed consent	97 (56.7)	145 (62.8)
Mental health well managed	47 (27.5)	118 (51.1)
Physical health well managed	75 (43.9)	24 (11.3)
Criteria for surgery met	41 (24)	67 (31.5)
Author availability for coordination	155 (90.6)	212 (91.8)

WPATH, World Professional Association for Transgender Health.

documented in 67 (32%) BH letters, and 212 (92%) authors stated their availability for coordination of care (Table 2).

Looking at chronic, physical health conditions that could impact surgery, the presence of overweight or obesity was documented in either the provider notes or the PCP referral letter for 105 (61%) patients. Among these patients, 29 (28%) had overweight or obesity documented in both the notes and the referral letter, 74 (70%) in only the notes, and 2 (2%) in only the referral letter. Chronic illnesses, such as asthma and migraine headaches, were documented in either the notes or the referral letter for 89 (52%) patients. Among these patients, 16 (18%) had chronic illness documented in both the notes and the referral letter, 70 (79%) in only the notes, and 3 (3%) in only the referral letter (Table 3).

Table 3. Documentation of Physical Health Conditions in Primary Care Provider Referral Letters and Internal Records

	Frequency of diagnosis in either internal records or PCP letters[a]	Of those who had the diagnosis		
		Diagnosis present in both	Diagnosis present in internal records only	Diagnosis present in PCP letters only
Overweight or obesity	105 (61.4)	29 (27.6)	74 (70.5)	2 (1.9)
Hyperlipidemia	3 (1.8)	0	1 (33.3)	2 (66.7)
Hypertension	2 (1.2)	1 (50.0)	1 (50.0)	0
Diabetes	2 (1.2)	1 (50.0)	1 (50.0)	0
Connective tissue disease	7 (4.1)	0	7 (100)	0
Other chronic illness[b]	89 (52.0)	16 (18.0)	70 (78.7)	3 (3.4)

[a]*N* = 171 patients whose records included a primary care provider referral letter.
[b]Common "Other Chronic Illness" examples included asthma and migraine.

With respect to BH, the most frequent conditions were anxiety and depression, documented for 144 (80%) and 138 (77%) patients, respectively. The diagnosis of anxiety was documented in both the notes and the BH referral letter for 47 (33%) patients, only the notes for 80 (56%), and only the referral letter for 17 (12%). The diagnosis of depression was documented in both the notes and the BH referral letter for 50 (36%) patients, only the notes for 81 (59%), and only the referral letter for 7 (5%) (Table 4).

Gender history documentation is at the core of the recommendation for referral letters, and a diagnosis of gender dysphoria was documented in both the notes and the BH referral letter for 164 (91%) patients, only the notes for 11 (6%), and only referral letters for 5 (3%). Treatment with hormone therapy was documented in both places for 138 (77%) patients, only the notes for 41 (23%), and only referral letters for 1 (< 1%). Gender identity was documented in both places for 168 (93%) patients, only the notes for 12 (7%), and only in referral letters for none (Table 5).

In a univariate linear regression assessing the association between type of surgical consultation and the number of WPATH *SOC* surgical criteria documented in referral letters, both PCP and BH letters for patients presenting for phalloplasty documented significantly more surgical criteria ($p < 0.001$) than letters on behalf of patients presenting for chest reconstruction (baseline category). In a multivariate linear regression controlling for patient age and internal referral, letters from BH providers documented significantly more surgical criteria for patients presenting for genital surgery ($p < 0.001$) in comparison to those presenting for chest surgery. Finally, PCP letters for patients receiving care internally reported significantly fewer surgical criteria ($p < 0.001$) in comparison to PCP letters for patients not seen internally, possibly due to recognition that surgical providers had access to internal records (Table 6).

Discussion

With a growing movement toward the use of informed consent models for gender-affirming medical care, there are questions about whether a similar model may be appropriate for accessing gender-affirming surgery. Currently, most insurers and providers follow the referral recommendations outlined by WPATH *SOC,* which describe a single referral letter for chest surgery and two for most genital surgeries, although they do state that, "For providers working within a multidisciplinary specialty team, a letter may not be necessary,

Table 4. Documentation of Behavioral Health Conditions in Behavioral Health Referral Letters and Internal Records

		Of those who had the diagnosis			
	Frequency of diagnosis[a] in either internal records or BH letters[b]	Diagnosis present in both	Diagnosis present in internal records only	Diagnosis present in BH letters only	Diagnosis present in both BH letters/in either[c]
Depression	138 (76.7)	50 (36.2)	81 (58.7)	7 (5.1)	6/19
Bipolar disorder	13 (7.2)	1 (7.7)	10 (76.9)	2 (15.4)	1/2
Post traumatic stress disorder	34 (18.9)	4 (11.8)	28 (82.4)	2 (5.9)	1/3
Anxiety	144 (80.0)	47 (32.6)	80 (55.6)	17 (11.8)	6/23
Obsessive compulsive disorder	15 (8.3)	4 (26.7)	9 (60.0)	2 (13.3)	0/2
Attention deficit/hyperactivity disorder (ADD/ADHD)	46 (25.6)	11 (23.9)	30 (65.2)	5 (10.9)	2/8
Autism spectrum disorder	13 (7.2)	5 (38.5)	7 (53.8)	1 (7.7)	0/3
Psychosis	5 (2.8)	0	5 (100)	0	0/0
Eating disorder	10 (5.6)	2 (20.0)	6 (60.0)	2 (20.0)	1/2
Suicidal ideation	71 (39.4)	5 (7.0)	59 (83.1)	7 (9.9)	0/3
Self-harm	100 (55.6)	13 (13.0)	87 (87.0)	0	0/1
BH medication	123 (68.3)	32 (26.0)	91 (74.0)	0	4/15

[a]Includes past medical history of condition (e.g., history of self-harm).
[b]*N* = 180 patients whose records include at least one BH letter.
[c]*N* = 51 patients whose records include two BH letters.

rather, the assessment and recommendation can be documented in the patient's chart."[5] In many clinics, referral letters from both BH and medical providers are required to access care and may stand in for some level of multidisciplinary assessment.

The purpose of this research was to answer two questions—whether referral letters provide useful additional information in the context of a multidisciplinary assessment and whether referral letters can provide a similar depth of information when multidisciplinary assessment is not available. As a growing number of surgeons are starting to perform gender-affirming procedures, it is important to understand whether referral letters are necessary and/or sufficient to establish readiness for treatment.

Documentation of SOC surgical criteria

The WPATH *SOC* document a series of criteria for accessing gender-affirming surgical procedures. The referral letters assessed in this study documented some criteria more consistently than others, and more criteria were documented for genital surgery patients than chest surgery patients, when controlling for age.

Letters did a poor job of documenting physical and BH conditions. While conditions like obesity and chronic illnesses such as asthma were common in the population of patients seeking surgery, more than two-thirds of patients with these conditions had no documentation of them in their referral information. For some patients, letters from BH providers did not include elements of gender history contained in the

Table 5. Documentation of Gender History in Behavioral Health Referral Letters and Internal Records

		Of those where it was documented anywhere			
	Frequency of *documentation* in either internal records or BH letters[a]	Documented in both internal records and BH letters	Documented in internal records only	Documented in BH letters only	Documentation present in both BH letters/in either[b]
Gender dysphoria	180 (100.0)	164 (91.1)	11 (6.1)	5 (2.8)	44/51
Puberty suppression	23 (12.8)	8 (34.8)	15 (65.2)	0	0/4
Hormone therapy	180 (100.0)	138 (76.7)	41 (22.8)	1 (0.6)	32/48
History of gender-affirming surgery	52 (28.9)	37 (71.2)	14 (26.9)	1 (1.9)	16/29
Top surgery patients	7 (5.7)	0	6 (85.7)	1 (14.3)	0/0
Bottom surgery patients	45 (77.6)	37 (82.2)	8 (17.8)	0	16/29
Gender identity	180 (100.0)	168 (93.3)	12 (6.7)	0	44/51
Living full time as gender identity	177 (98.3)	142 (80.2)	35 (19.8)	0	33/47

[a]N = 180 patients whose records include at least one BH letter.
[b]N = 51 patients whose records include two BH letters.

Table 6. Association Between Number of WPATH Surgical Criteria Documented and Age, Type of Surgical Consultation, and Internal Referral Status

No. of WPATH surgical criteria documented	Univariate analysis		Multivariate analysis	
	PCP letters, β (SE),	BH letters, β (SE)	PCP letters, β (SE)	BH letters, β (SE)
Patient age	**0.13 (0.03) $p < 0.001$**	**0.11 (0.03) $p < 0.001$**	0.05 (0.04)	0.01 (0.03)
Internal referral	**−1.71 (0.29) $p < 0.001$**	**−1.23 (0.26) $p < 0.001$**	**−1.45 (0.36) $p < 0.001$**	−0.57 (0.32) $p = 0.076$
Bottom surgery	**0.96 (0.34) $p < 0.005$**	**1.62 (0.27) $p < 0.001$**	0.03 (0.38)	**1.24 (0.33) $p < 0.001$**

Values in bold are significant at $p < 0.05$.
SE, standard error.

notes. Conversely, letters rarely documented gender history not already contained in the notes.

The vast majority of letters received by our team documented a diagnosis of gender dysphoria, while fewer—about two-thirds—addressed decision-making capacity, only half addressed management of existing health conditions, and about one-third stated that surgical criteria were met. Multiple factors may contribute to variation in documentation of WPATH surgical criteria. Some authors may be less familiar with caring for transgender and gender-diverse patients, and with the WPATH criteria.[14] However, prior studies suggest that even authors familiar with these criteria must make a number of considerations when composing referral letters.[13,14] Some of the considerations may be logistical. For example, a number of letters received by our team appeared to be "form" letters, which may be utilized for the purpose of efficiency. Nearly all authors expressed availability for coordination of care, indicating that they may view letters as only one component of communication with the surgical team. Some information may have seemed too obvious to include, as suggested by the fact that not all letters explicitly stated the patient's gender identity.

Another area of consideration in composing referral letters relates to the author's dual role as gatekeeper and advocate. For instance, authors may wish to compose a letter such that the patient feels comfortable with the information provided and the therapeutic alliance is maintained.[13,14] Some authors may prefer to provide only the most relevant or necessary information, to respect a patient's privacy or avoid standing in the way of medically necessary care. Both the author's and patient's views on the diagnosis of gender dysphoria may play a role, as some may prefer to avoid giving or receiving a diagnosis that is perceived as pathologizing a given identity or experience.[13,15–17]

The fact that a larger number of WPATH surgical criteria were documented for genital surgery patients in comparison to chest surgery patients may reflect an understanding of genital surgery as a more intensive procedure, both physically and emotionally. This result may also be expected as there are more recommended criteria for genital surgery patients than chest surgery patients; however, only criteria common to all surgical patients were included in this comparison. All patients in the study population underwent consultation for surgery with the same care team; as a result, authors seeking guidance from the surgical team on letter composition would have received similar information. However, insurance providers differed across patients, and may have varied in their requirements for referral letter content. Further research is needed to better understand the degree to which each of these competing priorities ultimately influences the information contained in referral letters.

In some cases, referral letters did not document components of gender history contained in the notes; at the same time, letters rarely documented components of gender history not already contained in the notes. Letters also generally documented physical and BH conditions less frequently than the notes. Moreover, our data show that patients do not tend to hide important medical or behavioral information from their providers. These findings suggest that, in some settings, pre-surgical assessment by a multidisciplinary team with extensive experience caring for transgender and gender-diverse people may be more useful than the requirement of referral letters in gathering comprehensive medical and gender history.

Although it could be argued that referral letter requirements encourage engagement in both therapy and primary care, prior studies of the experiences and preferences of transgender and gender-diverse patients have recognized gatekeeping as a barrier to care, and collaborative, shared decision-making as a priority for care.[18–20] One recent study found that an informed consent model of care for gender-affirming hormone therapy was associated with high patient satisfaction.[21] Past discussions of gatekeeping have also questioned whether the requirement for referral letters represents a departure from the way comparable care for cisgender patients is provided and a double standard.[17,22] Finally, transgender and gender-diverse patients report a number of barriers to care beyond gatekeeping,

and express a desire for improved provider competence in serving marginalized subpopulations of the community.[19,23] Well-trained, multidisciplinary care can potentially address both provider competence and gatekeeping issues.

Past scholarship has carefully examined the ethical implications of different models of care for the personal, bodily autonomy and self-determination of transgender and gender-diverse people.[6,9,17,24–27] Our findings suggest that a model of care involving multidisciplinary assessment may obviate the need for referral letters in some circumstances. Notably, these findings relate to the content of referral letters, but do not speak to the critically supportive role that gender-affirming counseling may play for some transgender and gender-diverse people.[28,29] Indeed, the high prevalence of anxiety and depression in our study population is consistent with prior research by two of this study's authors, and highlights the need for appropriate BH support around the time of surgery, regardless of the need for referral letters.[30] This is particularly true as depression after surgery is common, and even events perceived as having positive outcomes, such as gender-affirming surgery, can be stressful and occasionally destabilizing in the short term.[31–33]

Rather than proposing two separate referral standards for multidisciplinary clinics and independent surgeons, we suggest that the emphasis in forthcoming standards of care be on the type of information that providers need to assess rather than that information's source. Teams that have a provider who is trained in psychosocial assessment and knowledgeable about perioperative issues would therefore require less external documentation than surgeons relying on referring providers for that information. This would allow multidisciplinary teams to reduce the costs and time commitment of letter seeking without requiring surgeons working independently to either seek out such training or cease performing gender-affirming procedures – something that could potentially decrease patients' already limited access to surgery.[34]

There are several notable limitations of this study. First, this study by design quantitatively assessed the documentation of information in referral letters, including WPATH surgical criteria; however, it did not qualitatively assess the letter-writing process, and relies on prior research to hypothesize why certain information may have been documented or not. Second, this study does not account for the role that different insurance providers may have played in influencing what was ultimately included in a given referral letter. Finally, about half of this study's population had received care from an internal referral source at the time of surgical consultation, which is an important consideration regarding the external validity of these findings. In addition, information was occasionally extracted from those internal providers' notes in the shared EMR, and other multidisciplinary providers may not have similar access.

Generalizability of this study is also limited by several population factors. First, the included patient population is younger than seen in many primarily adult hospitals and clinics. Second, all patients included in this study had insurance coverage for their consultation, which is not reflective of the broader insurance status of transgender Americans or how care is accessed, as the insurance environment in Massachusetts is more favorable than in many other areas of the United States.[35,36] The included population was also primarily White, and the large quantity of missing racial and ethnicity data made it impossible to account for race in the analysis.

Conclusion

Referral letters received on behalf of transgender and gender-diverse young people presenting for gender-affirming chest and genital surgery documented WPATH-recommended surgical criteria variably and generally lacked sufficient information about physical and mental health comorbidities for accurate risk assessment and surgical decision-making. While letters documented gender dysphoria and author availability for coordination of care relatively consistently, some of the more sensitive aspects of individuals' health were consistently more thoroughly addressed through multidisciplinary assessment than through referral letters. Our research suggests that referral letters may function more as a barrier to surgical access than as a useful component of surgical decision-making, and that multidisciplinary pre-surgical assessment may be more useful, at least in some settings. Transgender and gender-diverse people face disproportionate barriers to accessing quality health care, even without the burden of mental health assessment as a surgical prerequisite. If referral letters are not a reliable source of information about physical and mental comorbidities, it may be worth considering removing them as a requirement from the standards of care.

Authors' Contributions

All three authors collaborated on the design of this study; initial draft was prepared by G.M.; article was

reviewed by E.R.B. and O.G. All authors have approved the final version.

Author Disclosure Statement

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Abbreviations Used

BH = behavioral health
EMR = electronic medical record
GeMS = Gender Multispecialty Service
PCPs = primary care providers
REDCap = Research Electronic Data Capture
SOC = standards of care
WPATH = World Professional Association for Transgender Health